First Health Services of Montana
ACUTE INPATIENT SERVICES
Continued Stay Request Form

First Health Services of Montana
To transmit request information:
FAX: 1-800-639-8982
PHONE: 1-800-770-3084

Mail: 4300 Cox Road
Glen Allen VA 23060

Acute Inpatient Continued Stay: Youth _____ Adult _____
(Out of State Only)

Please print or type:

PATIENT INFORMATION
Patient Name:
Medicaid Number: **SSN:**
FACILITY INFORMATION
Name: **Provider Number:**
Address:
City: **State:** **Zip Code:**
Telephone Number: **Fax Number:**
Number of Days Requested: **Start Date:**
CLINICAL INFORMATION
Any Changes in DSM-IV DIAGNOSIS:
Code: **Narrative:**
Code: **Narrative:**
Current Mental Status:
Justification for continued services at this level of care:
Precautions: SP Aggression Elopement Other

Processing may be delayed if information submitted is <u>illegible</u> or <u>incomplete</u>

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Name Last: _____ First: _____
SSN: _____

Current Medications (include dosage and start date):
Treatment Plan/Goals:
Scheduled Activities/Groups (describe participation):
Discharge Plan (please include estimated date of discharge):
Assessment completed by:
Title: **Date:**

For First Health's Use Only:
APPROVED**:** From_____ Thru_____ DENIED: From_____ Thru_____
Review Date:_____ Reviewer Signature: _____

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